

Joint Stakeholder Submission on Sexual and Reproductive Rights in Malaysia

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By:

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KEY WORDS: Sexual and Reproductive Health and Rights; Comprehensive sexuality education; Family Planning; access to modern methods of contraceptives; unmet needs for contraceptives, Abortion

1. This report is submitted jointly by FRHAM¹, RRAAM² and the Sexual Rights Initiative³ focusing on issues relating to sexual reproductive rights in Malaysia.
2. The following major issues are included in the submission:
 - a. The right to comprehensive sexuality education for young people
 - b. The right to information and access to effective and high quality services on sexual reproductive health including safe abortion services especially for young people to prevent unintended pregnancies, sexuality transmitted infections including HIV and unsafe abortion
 - c. The fulfilment of the right to access to modern methods of contraceptives; and meet unmet need for contraception

INTRODUCTION

3. Recent media reports and surveys indicate a high prevalence of unintended pregnancies and forced child-bearing for young people and lack of effective and high quality contraception putting them at risk to unintended pregnancies, unsafe abortion and STIs, including HIV and resulting in harmful impact on their health and well being. This clearly demonstrates that the sexual and reproductive health needs of adolescents and young people are neither understood nor met. Due to lack of comprehensive sexuality education and access to effective and high quality sexual and reproductive health services, young people's, especially young women's, right to health is violated.

RIGHT TO COMPREHENSIVE SEXUALITY EDUCATION:

4. At the 45th session of the Commission on Population and Development in New York during the General Debate on National Experience in Population matters: Adolescents and youth, (24 April 2012), the representative of Malaysia stated: "The introduction of the National Policy on Reproductive Health and Social Education in November 2009 further enhanced our efforts and paved the way for increased access to reproductive health education,

¹ Federation of Reproductive Health Associations, Malaysia (FRHAM) is formerly known as Federation of Family Planning Associations, Malaysia (FFPAM). FRHAM is the leading voluntary family planning, sexual and reproductive health organization in Malaysia. It is a federation of 13 State Member Associations (State MAs). It was established in 1958 with the aim of educating Malaysians in family planning and responsible parenthood, promoting and supporting effective family planning and sexual and reproductive health services.

² Reproductive Rights Advocacy Alliance Malaysia is a Malaysian Women's Rights and Health Group that supports women's rights to improved abortion and contraception services. It was formed on February 2nd, 2007 by twelve organisations and individuals committed to the belief that women have the right to access legal, safe and affordable contraceptive and abortion services, both as part of women's right to decide on reproductive matters and as the right to health.

³ The Sexual Rights Initiative is a coalition of organizations comprised of Action Canada for Population and Development (ACPD), Akahatá – Equipo de Trabajo en Sexualidades y Géneros, Coalition for African Lesbians, Creating Resources for Empowerment in Action (CREA; India), Egyptian Initiative for Personal Rights (EIPR) and Federation for Women and Family Planning (Poland).

information and services for adolescents and youths, stressing on positive values as well as responsible behaviours.”

5. The Malaysian Population and Family Survey (MPFS, 2004)⁴ reported that 2.2% of adolescents (3.8% boys and 0.6% girls) in Peninsular Malaysia have had sex, increasing from 1.2% among those under 15 years, 1.4% among those aged 15-19 and 6.3% among those 20-24. The survey also indicated a higher prevalence of sexual activity among urban youths at 2.4% as compared to their rural counterparts, at 1.8%.
6. A survey conducted by FRHAM prior to running its peer education programmes at the juvenile homes found that about two thirds of the boys have had sex, and their sexual debut is before 15 years of age,⁵ Lee’s study also reported the same age on sexual debut. In a cross-sectional study of 4,500 in-school adolescents aged 12-19 years in Negeri Sembilan, Lee (2006) reported that 5.4% of them had had sex and it was higher in male students than female students.¹
7. Despite the implementation of family planning program since 1966, the level of family planning knowledge among young people is rather low, partly because family planning services and information are not made available to them. The 2004 MPFS indicated that less than half of the respondents aged 13-24 have heard of at least one family planning method and it was even lower among those aged 13-16 years, at 34%. While almost all the young people have heard of HIV/AIDS, only 59.8% of males and 68.5% of females knew about STDs.
8. According to Bayer Schering Pharma’s “Talking Sex and Contraception Survey (2009)”, about 48% of young Malaysians aged 18-21 knew of a relative or friend who have had unintended pregnancy in the past few years.⁶ The other outcome of an unintended pregnancy is unsafe abortion resulting in harmful health consequences for young women.

RIGHT TO EFFECTIVE, ACCESSIBLE HIGH QUALITY SRH SERVICES:

9. At the 45th session of the Commission on Population and Development in New York during the General Debate on National Experience in Population matters: Adolescents and youth, (24 April 2012), the representative of Malaysia stated: “In addition, Malaysia provides universal access to healthcare services, including sexual and reproductive health services, to all adolescents in all primary and secondary healthcare facilities nationwide.”
10. Young people do not have full and easy access to effective and high quality sexual and reproductive health services. Under the Adolescent Health Policy⁷, SRH services, including family planning, are meant to be made available to all without discrimination. However, such services are not generally available in government facilities to unmarried women.

⁴ National Population and Family Development Board (2009), National Population and Family Survey 2004, Peninsular Malaysia

⁵ Federation of Reproductive Health Associations Malaysia (2009), Report of UNFPA Funded Project: MYSOR 209: Reaching Out to Disadvantaged Youth to address their SRH Needs and HIV Prevention through Peer Education Programme, 2008-2012.

⁶ Bayer Schering Pharma (2009), Talking sex and contraception Survey. TNS Healthcare. July 2009

⁷ Lee L K, Chen P C Y, Lee K K, Kaur J (2006), Premarital sexual intercourse among adolescents in Malaysia: a cross-sectional Malaysian School Survey, Singapore Med J: 476-481

11. Family planning services in the government clinics for adolescents are beginning to be initiated by MOH with guidelines on management of such cases especially for religious minorities including young Muslim women. However, such efforts are not generally known.

FULLFILLMENT OF RIGHT TO CONTRACEPTION AND UNMET NEED

12. The Contraceptive Prevalence Rates (CPR) for Malaysia is about 50 % for all contraceptive methods and 33% for modern methods since mid 1980s, which is low as compared with other countries in the region.
13. The CPR for any method in 2004 was only slightly lower than the level in 1988, but unmet need for any contraceptive method for the purpose of birth limitation had increased successfully during this period from 16% to about 25%
14. Interviews of abortion clients in a qualitative study conducted by one of the co-authoring organizations revealed their awareness of the need for reliable contraception to avoid 'accidental' pregnancies but they lacked sufficient knowledge and confidence to adopt a suitable and reliable method themselves.

RIGHT TO ACCESS SAFE ABORTION SERVICES

15. Demographer Prof Tey Nai Peng of University of Malay estimates that there are approximately 90,000 abortions in Malaysia annually.
16. Under UN Covenants, the right to health and right to life include access to reproductive health care and services. In his report to the General Assembly in 2011, the Special Rapporteur on the right of everyone to the highest standard of health emphasized that access to safe and legal abortion is a woman's right and depriving her of access including through criminalization and other legal or policy restrictions is a human rights violation that results in maternal mortality and morbidity.
17. Malaysia adopted a penal code amendment in 1989 allowing any registered medical practitioner to provide abortions where the continuance of the pregnancy poses a risk of injury to her mental and physical health. These provisions are stated in the Penal Code Act 574 (revised 1997) section 312.
18. However there has been very limited realisation of this right for women because no significant changes have taken place in actual service provision. It is a right only on paper. Surveys of doctors and medical students conducted by one of the co-authoring organization of this present submission have shown a large proportion unaware of the penal code provisions relating to abortion. They perceive abortion as an illegal procedure and take an anti-choice position on abortion.
19. Government clinics and hospitals provide abortions only for serious medical indications and almost never for mental health reasons. This includes reports of refusals in pregnancies resulting from rape given the poor mental health that can exist in these situations.
20. Laws and medical guidelines in Malaysia require, in addition to the consent of the woman seeking an abortion, the consent of the husband of a married Muslim woman to carry out an abortion. In the case of adolescent girls, the consent of parents or guardians is required.
21. Problems for women also lie in getting accurate information on available safe abortion services at affordable fees. The lack of such services in public hospitals together with the general perception that abortions are illegal allows exploitation by many private providers,

- both safe and unsafe, to charge exorbitant fees. It also encourages a judgmental attitude amongst providers to these clients, which runs completely against healthcare ethics.
22. In a survey carried out by one of the co-authoring organizations, the women surveyed had little knowledge of the procedures or of the laws governing abortions in Malaysia even though they know it is commonly practiced from hearsay. Their own experience of rejections and negative attitudes by doctors and nurses to their abortion requests both from the public and private sector suggested to them that abortions are probably illegal.
 23. This is also a reflection on the poor attitudes and lack of knowledge of healthcare providers on the law and policies regarding abortions. Healthcare providers should also be made aware of the code of professional ethics especially in relation to conscientious objections to contraception and abortions.
 24. Due to this inaccessibility of these services for a variety of reasons, women resort unsafe abortion even in cases where the law specifically provides for such rights. For women the fee is exorbitant in private hospital making access to these services almost impossible to a large segment of vulnerable population including the poor and adolescent girls who do not have the economic capacity to pay for such services.

RECOMMENDATIONS

25. The co-authoring organizations are willing to work with the government to ensure the realization of sexual and reproductive rights of women in Malaysia. To address the issues outlined above, the government of Malaysia, must implement the following recommendations:
 - a. Integrate comprehensive sexuality education as part of the formal school curriculum, delivered by well-trained and supported teachers. As well, special efforts need to be made to reach children out of school – often the most vulnerable to misinformation and exploitation.
 - b. Implement with immediate effect programmes on sexual and reproductive health services and family planning without discrimination. To this effect there should be built within these laws and policies effective monitoring mechanisms to ensure that marginalised and young people are not discriminated against while accessing these services.
 - c. Enact laws and policies protecting the confidentiality and privacy of all women who access sexual and reproductive health services. All service providers and doctors should be bound by the confidentiality clause to reduce stigma for young people accessing these rights.
 - d. Publish and provide sexual and reproductive health information and services that are currently provided by the Government to all women and especially make special efforts to reach those groups of people who are marginalised and the pockets of population. Clinics have to be set up in these areas to make these services more accessible.
 - e. Undertake evidence-based data collections on reasons for the low level of contraceptive use among women especially on specific target groups and pockets of population with unmet need for contraception. Effective strategies, including method mix would have to be developed in health education and promotion

activities toward the general practice of planned pregnancies and family planning.

- f. Remove any legal restriction and barriers on abortion services for all women and adolescent girls including punitive measures, spousal consent requirements and parental consent requirements.
 - g. Ensure access to Sexual and reproductive health services including abortion services should to all persons without any discrimination on age, class, marital status or minority status.
 - h. Take positive and concrete measures to train health care providers on sensitive, confidential and effective way to provide these services.
 - i. Actively disseminate the Penal Code provisions on abortion together with guidelines on interpretation especially to the healthcare community and social welfare staff. Abortion services should be included as part of reproductive health care for women and these services provided openly at all at government facilities both at peripheral and central levels in accordance with WHO Guidelines. Abortion services should always include sympathetic counselling on safe sex and contraception. Staff providing these services should undergo values clarification programmes to ensure they can treat their clients sympathetically without any internal conflict over their conscience over abortions.
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